Health Care Stabilization Fund

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Report

to the

Health Care Stabilization Fund Oversight Committee

On behalf of the

Health Care Stabilization Fund Board of Governors

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November 23, 2010

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REPORT

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HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

On Behalf of the
Health Care Stabilization Fund
Board of Governors

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PART I

Introduction

The Health Care Provider Insurance Availability Act was enacted in 1976 in response to a statewide medical professional liability insurance crisis. There were two principal features of the original Availability Act; the creation of the Health Care Stabilization Fund, and the establishment of a joint underwriting authority. There have been numerous amendments to the original Act during its thirty-four year history, but the two fundamental components have remained intact. For a more complete history, please refer to the Appendix.

Principal Features of the Contemporary Act

Health care providers are required to purchase professional liability insurance from commercial companies or from the joint underwriting authority (the Health Care Provider Insurance Availability Plan). The insurance policy must provide minimum coverage limits of $200,000 per claim with an annual aggregate total limit of $600,000 coverage. The health care providers are also required to select one of three options for additional coverage via the HCSF. Those options are:
$100,000 per claim with $300,000 annual aggregate,
$300,000 per claim with $900,000 annual aggregate, or
$800,000 per claim with $2,400,000 annual aggregate.

Most health care providers choose the highest coverage option which, when combined with the primary level of insurance, results in a total of $1-million per claim with an annual aggregate limit of $3-million. Some health care providers, particularly large medical centers and high risk specialists, purchase excess liability insurance in addition to the HCSF coverage.

There are sixteen categories of health care providers statutorily required to participate in the HCSF: (1) three types of medical care facilities; hospitals, ambulatory surgery centers, and recuperation centers, (2) all three licensees under the Healing Arts Act; D.C.s, D.O.s, and M.D.s, (3) podiatrists, (4) nurse anesthetists, (5) professional corporations incorporated by health care providers, (6) limited liability companies formed by health care providers, (7) partnerships consisting of health care providers, (8) not-for-profit corporations incorporated by health care providers, (9) graduate medical education programs affiliated with the University of Kansas, (10) dentists certified by the Board of Healing Arts to administer anesthesia, (11) psychiatric hospitals, and (12) community mental health centers. State psychiatric hospitals and state hospitals for the mentally disabled are specifically excluded from the Availability Act definition of health care provider.

The licensed health care professionals and medical care facilities are required to comply with the Availability Act as a condition of licensure. Because the corporations, limited liability companies, and partnerships formed by health care providers are not licensed, there is no immediate enforcement method. The HCSF Board of Governors must rely upon insurance company representatives to question licensed health care providers in order to ascertain whether they own an interest in one of the defined business entities that is subject to the Availability Act. Then we must review pertinent documents to determine whether the business meets the statutory criteria.

The Commercial Insurance Market

The Availability Act promotes marketing of commercial medical liability insurance in two principal ways. First, it limits the commercial insurer's maximum liability per claim to $200,000 as well as limiting the annual aggregate losses to $600,000 for any health care provider. Second, by creating a joint underwriting association, the Act allows insurers to engage in conservative underwriting practices.

Currently, there are several commercial insurance companies and risk retention groups providing the primary layer of medical liability insurance in Kansas. Some of those companies and RRGs offer coverage only to a specific profession or specialty group. As a result, some of them insure only a few health care providers.

During this calendar year we were contacted by two more insurance companies that are interested in selling professional liability insurance to Kansas health care providers. When we are contacted by such companies, we always invite them to our office or to a webinar to explain the Kansas Health Care Provider Insurance Availability Act so they can make a well-informed decision prior to doing business in Kansas.

The Availability Plan

Most Kansas health care providers purchase professional liability insurance from one of the commercial companies, but there are some who cannot. As a result, there are over 400 health care providers participating in the Health Care Provider Insurance Availability Plan. These health care professionals and facilities are not necessarily marginal risks. Some of these health care providers are somewhat unique and simply cannot find a commercial insurance product available for their specialty or service. Examples are residents in training who want to work outside of their training program (moonlighting) and *locum tenens* health care providers who need to purchase short-term insurance coverage that applies only to their temporary Kansas practice.

The existence of the Availability Plan allows commercial insurers to reject applicants who have a history of claims or are under investigation by a licensing agency. While this promotes a favorable insurance market for commercial companies, it also creates a potential liability for the Stabilization Fund. The Availability Plan is unlike the typical joint underwriting authority which assesses the commercial insurers when losses and expenses exceed premium income. Instead, subsection (a) of K.S.A. 40-3413 stipulates that when the plan earns premiums in excess of losses and expenses, the surplus shall be transferred to the Stabilization Fund. Conversely, in those years when losses and expenses exceed premiums collected, the Fund is required to subsidize the Plan. During the most recent ten-year period, the Plan's total income has exceeded total losses by $2,716,212.

Self-Insured Health Care Providers

K.S.A. 40-3414 allows a health care provider that meets certain criteria to make application to the Board of Governors to become an authorized self-insured. The principal criterion is that the health care provider's annual premium for basic coverage must exceed $100,000. There is a provision that allows a health care system that owns two or more medical care facilities to aggregate premium costs to meet the $100,000 requirement. This statute also provides that prior to issuance of a certificate of self-insurance the Board of Governors shall consider: (1) the financial condition of the applicant, (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims, (3) the amount and liquidity of assets reserved for the settlement of claims or potential claims, and (4) any other relevant factors.

Once a health care provider has met the statutory requirements and a certificate of self-insurance has been issued, the certificate is continuous. The self-insured health care provider must, however, resubmit the required information each year for re-evaluation of eligibility. The Board may cancel an organization's certificate of self-insurance for "reasonable grounds," but must provide notice and opportunity for a hearing in accordance with the Kansas Administrative Procedure Act.

There are currently fourteen self-insured medical care facilities in Kansas. They are:

Shawnee Mission Medical Center (1989)
Stormont Vail Healthcare (1989)
Via Christi Regional Medical Center (1995)
Cotton O'Neil Endoscopy (1997)
Stormont Vail Single Day Surgery (1997)
Salina Regional Health Center (2001)
Providence Medical Center (2002)
St. Francis Hospital and Medical Center (2002)
St. John Hospital (2002)
Promise Regional Medical Center (2005)
St. Luke's South Hospital (2005)
Shawnee Mission Surgery Center (2006)
Cushing Memorial Hospital (2007)
Shawnee Mission Prairie Star (2009)

K.S.A. 40-3414 also declares certain state facilities for veterans, as well as faculty and residents at the University of Kansas Medical Center and its affiliates, to be self-insured. These medical care facilities are not subject to Board review or approval because they are statutorily self-insured. Furthermore, the Statute creates a unique relationship between the HCSF Board of Governors and KU Medical Center.

University of Kansas Medical Center

In 1989 the Legislature decided to self-insure the basic ($200,000/claim) professional liability of residents in training and the full time faculty members at the University of Kansas Medical Center. The Insurance Commissioner was delegated responsibility for initial payment of claims and related expenses from the Stabilization Fund, to be subsequently reimbursed by faculty foundations and the State of Kansas. The financial commitment of the faculty foundations was limited not to exceed $500,000 per year.

This statutory duty was later transferred to the Health Care Stabilization Fund Board of Governors along with general responsibility for administration of the Health Care Stabilization Fund. Normally, the HCSF Board of Governors serves as a third party administrator and is periodically reimbursed by the State for claims paid on behalf of the residents and faculty at KU Medical Center (both Kansas City and Wichita). This arrangement was effective and successful for twenty years.

In February 2009 and again in July 2009 the Secretary of Administration imposed State General Fund allotments which discontinued reimbursements to the Stabilization Fund for those liability claims and related expenses paid on behalf of residents and faculty at KUMC. When the Health Care Stabilization Fund Board of Governors questioned the Secretary's authority to discontinue the State's statutory obligation to reimburse the Stabilization Fund, the Attorney General opined that the Secretary acted within lawful power delegated by the Legislature. As a result, it became necessary for the HCSF Board of Governors to write off $2,919,600 as an uncollectible account receivable from the State of Kansas. This was an indirect tax on Kansas health care providers.

Our Chief Attorney has prepared a detailed report describing FY2010 claims activity which we administered on behalf of these self insured programs. The report includes historical data as well as new information for the fiscal year that ended June 30, 2010. That document is included in Part II of this report.

2010 Senate Bill 414

Early in the 2010 Session the Kansas Medical Society requested introduction of a bill that made it unlawful for the Secretary of Administration to withhold reimbursements to the HCSF for claims and expenses paid on behalf of the State. Senate Bill 414 was supported by the HCSF Board of Governors, the Kansas Hospital Association, the University of Kansas Physicians, the Kansas Association of Osteopathic Medicine, and the Kansas Chiropractic Association as well as the Medical Society. But because the Governor's recommended budget proposed that the State withhold reimbursements to the HCSF again in FY2011 as well as FY2010, there was a fiscal note attached to SB414 indicating a cost to the State General Fund.

During Senate Committee of the Whole debate, SB414 was amended to create the equivalent of a line of credit whereby the HCSF will continue to pay claims and expenses on behalf of the State, but will not be reimbursed until FY2014. Beginning in July 2013, the accrued amount for claims paid in fiscal years 2010 - 2013 is to be reimbursed in annual installments of twenty percent per year. In addition, the normal reimbursement arrangement will be resumed at that time.

It is noteworthy that SB414 was passed by the Senate 40-0 and was passed by the House 122-0. The bill became law upon publication in the Kansas Register on April 8, 2010.

The Board's Statutory Report

Subsection (b) of K.S.A. 40-3403 imposes specific reporting requirements on our Board of Governors. This section of our report addresses those reporting requirements for the fiscal year that ended June 30, 2010.

1. Net premium surcharge revenue collections amounted to $26,394,273. This was a 6.1 percent increase compared to FY2009.
2. The lowest surcharge rate for a health care professional was $50 for a chiropractor in his or her first year of Kansas practice who selected the lowest coverage option ($100,000 per claim and $300,000 annual aggregate limits).
3. The highest surcharge rate for a health care professional was $16,552 for a neurosurgeon with five or more years of Health Care Stabilization Fund liability exposure who selected the highest coverage option ($800,000 per claim and $2.4 million annual aggregate limits). If a Kansas resident neurosurgeon was also licensed to practice in Missouri, the 25% Missouri modification factor would result in a total premium surcharge of $20,690.

4. There were 32 medical professional liability cases involving 47 Kansas health care providers decided as a result of a jury trial. Of these 32 cases, only seven resulted in verdicts for the plaintiff. One case resulted in a split verdict and three cases ended in mistrial. Only four claims in three cases resulted in Stabilization Fund obligations. Compensation awarded in those three cases resulted in Stabilization Fund obligations amounting to $1,224,821.
5. Fifty four cases involving 61 claims were settled resulting in Health Care Stabilization Fund obligations amounting to $19,745,200. The average Stabilization Fund compensation per claim was $323,692, a 9.9 percent increase compared to FY2009. These amounts are in addition to compensation paid by primary insurers (typically $200,000 per claim, unless the health care provider has become inactive).
6. Because of both past and future periodic payment of compensation, the amounts reported above in items four and five were not necessarily paid during FY2010. Total claims paid during the fiscal year amounted to $26,174,458. This amount included $600,000 paid to claimants on behalf of insurance companies that tendered their coverage limits to the Fund. Therefore net claims paid from the HCSF during FY2010 amounted to $25,574,458.
7. The financial report as of June 30, 2010 accepted by the Board of Governors indicated assets amounting to $228,573,232 and liabilities amounting to $225,800,123.

In addition to these statutory reporting requirements, our Chief Attorney, who is also our Deputy Director, has prepared a detailed, historical analysis of claims activity. That analysis is contained in Part II of this report.

Health Care Stabilization Fund

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Medical Professional Liability Experience
Fiscal Year 2010

By Rita Noll
Deputy Director and Chief Attorney

This report for the Board of Governors of the Health Care Stabilization Fund summarizes medical professional liability experience in Kansas during fiscal year 2010. The report is based on statistical data gathered by the Fund in administering the Health Care Provider Insurance Availability Act.

This report on medical malpractice litigation is based on all claims resolved in fiscal year 2010 including judgments and settlements. By far, the majority of medical malpractice cases are resolved by settlement rather than by jury trial.

Medical professional liability refers to a claim made against a health care provider for the rendering of or failure to render professional services (K.S.A. 40-3403). Health care provider is defined in K.S.A. 40-3401 to include physicians, chiropractors, podiatrists, registered nurse anesthetists, and certain medical care facilities. Fiscal year 2010 covers the period of time from July 1, 2009 through June 30, 2010.

It should be noted that dollar amounts will not necessarily correspond with the agency's accounting and budgeting documents because claims are not necessarily paid in the same fiscal year that the settlement was approved by the court, or the judgment was rendered by a jury.

MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

A. Jury Verdicts

From HCSF data, 32 medical malpractice cases involving 47 Kansas health care providers were tried to juries during fiscal year 2010. Of these, 27 cases were tried to juries in Kansas courts, four cases involving Kansas health care providers were tried to juries in Missouri, and one case involving a Kansas health care provider was tried in Nebraska. These jury trials were held in the following jurisdictions:

Johnson County	8
Wyandotte County	5
Sedgwick County	4
Jackson County, MO	3
U.S. District Court	2
Atchison County	1
Cowley County	1
Crawford County	1
Leavenworth County	1
Neosho County	1
Riley County	1
Saline County	1
Sherman County	1
Clay County, MO	1
Gage County, NE	1

Of the 32 cases tried, 21 resulted in complete defense verdicts. Plaintiffs won verdicts in seven cases. One case resulted in a "split" verdict, and three cases ended in mistrial. Juries returned verdicts for plaintiffs and awarded damages for the following claims:

Case	Court	Verdict Amount*	HCSF Amount*
Plaintiff v. Doctor	Johnson County	$87,500.00	
Plaintiff v. Doctor	Sedgwick County	$2,384,288.26	$800,000.00
Plaintiff v. Hospital	Sedgwick County	$437,293.00	$237,293.00
Plaintiff v. Doctor	Johnson County	$90,000.00	
Plaintiff v. Doctor	Wyandotte County	$334,041.85	$134,041.85
Plaintiff v. Doctor	Wyandotte County	$253,486.25	$53,486.25
Plaintiff v. Doctor	Crawford County	$23,375.00	
		$23,077.02 settled	
Plaintiff v. Doctor	Neosho County	$31,410.18**	
Plaintiff v. Doctor	Johnson County	$178,860.90	

*Note: Cases may be on appeal. ** New trial granted.

This year's experience compares to previous fiscal years as follows:

	FY10	FY09	FY08	FY07	FY06	FY05	FY04	FY03	FY02
Total	32	27	34	36	29	34	28	27	19
Defense Verdict	21	20	25	31	23	22	23	23	10
Plaintiff Verdict	7	5	4	5	6	7	3	3	6
Split Verdict	1	1	1			3	2		2
Mistrial	3	1	4			2		1	1

B. Settlements

Claims settled by the Fund. During FY 2010, 61 claims in 54 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $19,745,200. This compares to last year's total of $23,867,283.72 to settle 81 claims in 72 cases. These figures do not include settlement contributions by primary or excess insurance carriers. The settlement amounts are payments made, or to be made, by the HCSF in excess of primary coverage or on behalf of inactive health care providers. The average Fund settlement amount per claim for FY 2010 claims is $323,692. This amount compares to last year's average of $294,658.

Fiscal Year	Number of Claims/Cases	Fund Amount	Settlement Average
FY 2010	61/54	$19,745,200.00	$323,692
FY 2009	81/72	$23,867,283.72	$294,658
FY 2008	65/57	$17,352,500.00	$266,962
FY 2007	61/53	$20,929,250.00	$343,102
FY 2006	89/81	$24,917,984.00	$279,977
FY 2005	90/74	$23,544,658.00	$261,607
FY 2004	79/64	$18,905,505.00	$239,310
FY 2003	87/76	$17,483,778.00	$200,963
FY 2002	67/58	$16,173,742.00	$241,399
FY 2001	54/44	$15,592,748.80	$288,755
FY 2000	69/59	$20,071,607.50	$290,893
FY 1999	70/57	$18,344,368.15	$262,062
FY 1998	60/53	$11,461,345.13	$191,022
FY 1997	39/33	$12,448,978.83	$319,204
FY 1996	67/51	$21,808,406.14	$325,498
FY 1995	42/36	$15,344,749.98	$365,351
FY 1994	59/45	$19,526,821.53	$330,963
FY 1993	45/37	$18,239,093.06	$405,313
FY 1992	33/27	$ 7,890,119.83	$239,095
FY 1991	44/NA	$16,631,491.94	$377,988

Health Care Stabilization Fund individual claim settlement contributions during fiscal year 2010 ranged from a low of $10,000 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

	FY10	FY09	FY08	FY07	FY06	FY05	FY04	FY03	FY02
$000-$9,999	0	2	0	0	0	0	0	3	2
$10,000-$49,999	5	12	6	6	9	5	13	11	7
$50,000-$99,999	11	10	12	7	12	13	18	18	7
$100,000-$499,999	29	37	34	27	51	58	37	44	40
$500,000-$800,000	16	20	13	21	17	14	11	11	11
Total Claims	61	81	65	61	89	90	79	87	67

Of the 61 claims involving Fund monies, the Fund provided primary coverage for inactive health care providers in 12 claims. Also, the Fund "dropped down" to provide first dollar coverage for two claims in which aggregate primary policy limits were reached. Primary insurance carriers tendered their policy limits to the Fund in 47 claims. Therefore, in addition to the $19,745,200 incurred by the Fund, primary insurance carriers contributed $9,400,000 to the settlement of these claims. Further, seven claims involved contribution from a health care provider or an insurer whose coverage was excess of Fund coverage. The total amount of these contributions was $14,972,500.

Total settlement amounts for claims involving Fund contribution for the last sixteen fiscal years are as follows:

Fiscal Year	Primary Carriers	HCSF	Excess Carriers
FY 10	$ 9,400,000.00	$19,745,200.00	$14,972,500.00
FY 09	$11,471,170.00	$23,867,283.72	$ 4,954,830.00
FY 08	$10,612,500.00	$17,352,500.00	$ 2,425,000.00
FY 07	$ 9,488,750.00	$20,929,250.00	$ 3,125,000.00
FY 06	$14,580,000.00	$24,917,984.00	$ 5,089,425.00
FY05	$15,800,000.00	$23,544,658.00	$10,450,000.00
FY04	$12,600,000.00	$18,905,505.00	$ 8,550,000.00
FY03	$14,200,000.00	$17,483,778.00	$ 2,787,500.00
FY02	$11,400,000.00	$16,173,742.00	$ 2,680,000.00
FY01	$ 8,800,000.00	$15,592,748.80	$ 6,710,000.00
FY00	$12,515,000.00	$20,071,607.50	$ 2,465,000.00
FY99	$11,800,000.00	$18,344,368.15	$ 8,202,500.00
FY98	$ 8,825,000.00	$11,461,345.13	$ 3,040,000.00
FY97	$ 6,046,667.33	$12,448,978.83	$ 1,117,500.00
FY96	$11,000,000.00	$21,808,406.14	$ 1,065,000.00
FY95	$ 7,000,000.00	$15,344,749.98	(Not available)

Claims settled by primary carriers. In addition to the settlements discussed above, the HCSF was notified that primary insurance carriers settled an additional 110 claims in 92 cases. The total amount of these reported settlements is $8,958,622.00. These figures compare to previous fiscal years as follows:

Fiscal Year	Settlement Reported Claims/Cases	Amount Paid by Primary Insurance Carriers
2010	110/92	$ 8,958,622.00
2009	90/80	$ 7,182,241.00
2008	104/88	$ 8,486,032.00
2007	167/146	$10,870,339.00
2006	110/98	$ 8,545,218.00
2005	103/88	$ 8,058,894.00
2004	99/85	$ 6,978,801.00
2003	122/99	$ 9,087,872.00
2002	141/124	$10,789,299.00
2001	109/88	$ 8,124,459.00
2000	116/102	$ 8,390,869.00

C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2010 the HCSF incurred $19,745,200 in 61 claim settlements and became liable for $1,224,821 as a result of four jury verdicts for a total 65 claims. The following figures compare total Fund settlements and awards since the inception of the Health Care Stabilization Fund.

Fiscal Year	Total Claims	Settlements & Awards	Average Per Claim
FY 2010	65	$20,970,021.10	$322,615.71
FY 2009	85	25,505,208.67	300,061.28
FY 2008	68	19,085,004.00	280,661.82
FY 2007	64	22,589,655.27	352,963.36
FY 2006	90	25,017,984.00	277,977.60
FY 2005	97	26,119,569.91	269,273.30
FY 2004	81	19,055,505.00	235,253.15
FY 2003	90	18,295,320.32	203,281.34
FY 2002	71	17,467,033.19	246,014.55
FY 2001	58	17,114,748.80	295,081.86
FY 2000	73	20,868,192.91	285,865.66
FY 1999	71	21,344,368.15	300,624.90
FY 1998	66	12,834,705.13	194,465.23
FY 1997	41	13,653,618.34	333,015.08
FY 1996	70	23,258,406.14	332,262.94
FY 1995	45	17,023,882.17	378,308.49
FY 1994	65	21,194,765.96	326,073.32
FY 1993	48	24,614,093.06	492,281.86
FY 1992	35	8,824,834.14	252,138.11
FY 1991	49	19,666,797.32	401,363.21
FY 1990	48	13,627,222.20	283,700.46
FY 1989	58	18,713,543.00	315,750.00
FY 1988	51	13,402,756.00	262,799.00
FY 1987	47	13,296,808.00	282,910.00
FY 1986	42	11,492,857.00	273,639.00
FY 1985	41	15,152,042.00	369,562.00
FY 1984	34	9,538,741.00	280,551.00
FY 1983	25	6,522,369.00	260,894.00
FY 1982	24	3,060,126.00	127,505.00
FY 1981	8	1,760,645.00	220,080.00
FY 1980	0	0.00	-
FY 1979	3	203,601.00	67,867.00
FY 1978	0	0.00	-
FY 1977	1	137,500.00	137,500.00

D. New Cases by Fiscal Year

The Health Care Stabilization Fund was notified of 290 cases during fiscal year 2010. The following chart lists the number of new cases opened in each fiscal year.

FY	Number of Cases
2010	290
2009	310
2008	329
2007	304
2006	457
2005	336
2004	368
2003	392
2002	361
2001	341
2000	294
1999	319
1998	293
1997	318
1996	296
1995	326
1994	247
1993	263
1992	245
1991	230
1990	205
1989	251
1988	285
1987	320
1986	276
1985	245
1984	175
1983	153
1982	124
1981	98
1980	87
1979	50
1978	19
1977	2

University of Kansas Foundations and Faculty; Residents Self-Insurance Programs/Primary Coverage Reimbursement to the Health Care Stabilization Fund

I. KU Foundations and Faculty

Foundation Self-Insurance Program Costs

FY 2010	FY 2009	FY 2008	
$ 625,000.00	$1,800,000.00	$435,000.00	Settlement Amounts
$ 820,658.21	$ 893,099.94	$531,327.58	Attorney Fees and Expenses
$1,445,658.21	$2,693,099.94	$966,327.58	Totals

Reimbursable Amounts

FY 2010	FY 2009	FY 2008	
$ 500,000.00	$ 502,375.42	$497,623.96	Reimbursement - Private Practice Reserve Fund
**$ 945,658.21	*$2,190,724.52	$468,703.62	Reimbursement - State General Fund
$1,445,658.21	$2,693,099.94	$966,327.58	Totals

*Amount not reimbursed FY 2009

**Amount not reimbursed FY 2010

II. KU and WCGME Residents

Residents Self-Insurance Program Costs

FY 2010	FY 2009	FY 2008	
0	0	$200,000.00	Settlements, WCGME Residents
$ 202,500.00	$200,000.00	0	Settlements, KU Residents
$ 481,927.32	$201,523.03	$301,775.96	Fees & Expenses, WCGME Residents
$ 517,290.69	$410,969.63	$146,493.84	Fees & Expenses, KU Residents
$1,201,718.01	$812,492.66	$648,269.80	Totals

Reimbursable Amounts

FY 2010	FY 2009	FY 2008	
$ 481,927.32	$201,523.03	$501,775.96	WCGME Reimbursement - State General Fund
$ 719,790.69	$610,969.63	$146,493.84	KU Reimbursement - State General Fund
***$1,201,718.01	$812,492.66	$648,269.80	Totals - State General Fund

*$ 83,616.87 *Amount reimbursed FY 2009

**$728,875.79 **Amount not reimbursed FY 2009

***No amounts reimbursed FY 2010

III. Expenditures by Fiscal Year

Fiscal Year	Foundations and Faculty*	KU and WCGME Residents**
2010	$1,445,658.21	$1,201,718.01
2009	2,693,099.94	812,492.66
2008	966,327.58	648,269.80
2007	2,037,227.63	1,194,968.11
2006	1,407,837.70	871,719.27
2005	1,706,763.57	1,749,032.25
2004	1,825,116.29	2,787,112.99
2003	1,113,326.84	1,418,927.85
2002	583,566.19	723,834.54
2001	1,540,133.41	953,304.62
2000	691,253.39	735,633.12
1999	1,371,640.73	645,997.65
1998	1,018,435.78	1,072,324.05
1997	1,111,787.72	999,388.16
1996	4,003,062.51	1,331,521.75
1995	255,117.85	534,124.84
1994	1,959,284.79	574,758.65
1993	1,453,444.21	650,033.67
1992	645,670.10	810,703.77
1991	435,540.69	458,561.65
1990	261,035.55	120,796.12

*Foundations and Faculty:
Amounts up to $500,000 are reimbursed from the Private Practice Reserve Fund.
Amounts over $500,000 are reimbursed from the State General Fund.
FY 09 and FY 10 HCSF received reimbursement only from the Private Practice Reserve Fund.

**KU and WCGME Residents:
All amounts are reimbursed from the State General Fund.
FY 09 HCSF was reimbursed only $83,616.87. FY 10 HCSF received no reimbursement.

Amounts to be received from the State General Fund are carried forward as receiveables.

IV. Monies Paid by the Health Care Stabilization Fund for Excess Coverage Claims

	FY 10	FY 09	FY 08	FY 07	FY 06
WCGME Residents	0	0	$ 78,000	$1,600,000	0
K.U. Residents	0	$ 800,000	0	0	0
Faculty, Foundations	$970,000	$3,262,500	$135,000	$1,475,000	0
Total	$970,000	$4,062,500	$213,000	$3,075,000	0

PART III

Premium Surcharges

The HCSF Board of Governors has numerous statutory duties and responsibilities. The most important responsibility is delegated in K.S.A. 40-3404(a). It says, "the board of Governors shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each year." That subsection goes on to say, "Such premium surcharge shall be an amount based upon a rating classification system established by the board of governors which is reasonable, adequate and not unfairly discriminating."

It is extremely important to maintain adequate unassigned reserves in order to be prepared for unforeseen circumstances. For example, the economic recession resulting in substantially lower interest rates has already reduced the future return on investments when those investments mature. Another example is the potential impact of an unfavorable court decision. If, for example, the courts would declare unconstitutional the statutory limit on non-economic damages, we would immediately reexamine all open cases to determine whether sufficient reserves have been assigned to them. In addition, estimated liabilities would suddenly increase by a significant amount.

You may recall that the Board of Governors decided to increase the FY2010 HCSF premium surcharge rates for the majority of health care providers who practice in Kansas. The revenue goal was achieved and the Fund's financial position improved somewhat. This year the Board decided it was unnecessary to adjust surcharge rates for fiscal year 2011. In large part, this was because of passage of SB414 and the expectation that eventually the State will reimburse the HCSF for self insurance of the KU Medical Center physician faculty and residents.

These decisions are guided by periodic actuarial analysis of the Fund's estimated liabilities. The Availability Act specifically authorizes the Board of Governors to contract with an actuary to obtain the information needed to assure that premium surcharges are "reasonable, adequate and not unfairly discriminating." The Fund's Actuary, Russel L. Sutter of Towers Watson has prepared the following update for the Oversight Committee.

Health Care Stabilization Fund

Fiscal Year 2011 Surcharge Issues

A presentation to the HealthCare Stabilization Fund Oversight Committee
by Russel L. Sutter

November 23, 2010

This document was designed for discussion purposes only.
It is incomplete, and not intended to be used, without the accompanying oral presentation and discussion.

TOWERS WATSON

Table of Contents

- This presentation will address the following topics:
  - Our projections of unassigned reserves at June 2010 and June 2011
  - Our findings regarding Fund loss experience
  - The experience and indications by provider class
  - A history of surcharge rate changes
- Questions are welcome throughout the presentation.
- This presentation may be considered an addendum to our report dated April 16, 2010. As such, the **Distribution and Use** and **Reliances and Limitations** sections of that report apply to this presentation.

Conclusions

- Our forecasts of the Fund's position at June 30, 2010 and June 30, 2011 were as follows (in $millions)

Category	June 30, 2010		June 30, 2011	
	Undiscounted	Discounted	Undiscounted	Discounted
Assets	$ 223.1	$ 223.1	$ 228.1	$ 228.1
Liabilities	209.0	184.0	215.4	189.7
Unassigned Reserves	$ 14.0	$ 39.1	$ 12.7	$ 38.4

- The forecasts were based on a review of Fund loss data as of December 31, 2009. The liabilities exclude amounts other than losses and loss expenses.

Conclusions – Continued

- The undiscounted liabilities at 6/30/10 are approximately $8.7 million lower than anticipated in our 2009 study
- The estimates above assume
  - No change in surcharge rates for FY2011
  - A 2.0% rate for the discounted liabilities
  - Full reimbursement for KU/WCGME claims for FY2010 through FY2013, but delayed until FY2014
- We suggested that the Board consider modest changes by class, perhaps with no longer using uniform percentages for classes 15-21. We also suggested leaving surcharge rates unchanged
- The Board of Governors did not change surcharge rates for FY2011

Liabilities at June 30, 2010

- The split of the Fund's estimated liabilities for unpaid losses and loss expenses at June 30, 2010 is as follows (in $millions)

	Undiscounted	Present Value at 2.0%
Active Providers – Losses	$ 94.6	$ 90.8
Active Providers – Expenses	14.3	13.6
Inactive Providers – Known at 6/30/10	10.0	9.8
Inactive Providers – Tail	79.6	60.3
Future Payments	12.9	12.3
Claims Handling	6.1	5.1
Other	3.6	3.6
Subtotal – Gross Liabilities	221.1	195.5
Reimbursements	-12.1	-11.5
Total Net Liabilities	$209.0	$184.0

Changes from Prior Forecasts

- The table below shows how our forecasts changed from the 2009 study. All amounts are in $millions

Category	Fiscal Years	2009 Estimate	Current Forecast	Change in Estimates
Active Provider Losses	1977-2010	$600.5	$584.1	-$16.4
Active Provider Expenses	1982-2010	73.5	74.0	+0.5
Inactive Provider Claims	1982-2010	57.1	57.3	+0.2
Inactive Providers – Tail	2011-2047	54.8	53.4	-1.4
Reimbursable Claims	1985-2010	58.5	60.3	+1.8

Observations

- Factors influencing the changes noted on the prior page for active provider losses include the following
  - Settlements were lower than expected during CY2009
    - Expected $26.0 million; actual were $19.3 million
  - Loss reserves on open claims dropped during CY2009 from $53.3 million to $45.6 million
  - The number of open claims dropped from 239 to 208
  - The net increase in claims (settled plus change in open) was +17, well below Fund average of 65-70 for FY2004-2008.
  - As a result, our forecast of the prospective year's losses are $28.5 million, the first sub-$30 million forecast in several years

Miscellaneous Observations

- Since 1999, the Fund's surcharge revenue has ranged from 23% of basic coverage premium (2005) to 33% of premium (2001). The FY2009 ratio was 32.5%, up from 29.1% in FY2008, and the 4th consecutive year with an increase
- Availability Plan insureds increased from 251 in FY2001 to 674 in FY2006, but have dropped since then. In FY2009, there were 532 Plan insureds
- The average yield-to-maturity on the Fund's investments at December 2009 was surprisingly high (4.67%), given market rates at that time

Findings – Indications by Provider Class

- Our analysis of experience by Fund class continued to show differences in relative loss experience among classes. However, the variability has narrowed since our initial study in 2005, partly due to the rate changes in FY06 through FY10.

Relative Rate Change Indicated		
Decrease > 12%	**Increase < 12% or Decrease < 12%**	**Increase > 12%**
Class 16 (-32%)	Class 10 (-12%)	Class 20
Class 9	Class 19	Class 3
Class 1	Class 2	Class 11
Class 6	Class 5	Class 15 (+68%)
Class 14	Class 17	
Class 18	Class 8	
Class 12	Class 4 (+10%)	
Class 7		
Class 13		

- Page 11 has further details on class experience and definitions.

History of Surcharge Rate Changes

- The table below shows changes in surcharge rates since 1999. Excludes the implementation of the MO surcharge in 2001 and subsequent increase in 2008

Fiscal Year	Overall Change	Classes 1-14 Range of Rate Changes		Classes 15-21 % Basic Coverage Premium*
		Low	High	
1999	-31%	-31%		30%
2000	+15%	+15%		35%
2001	+10%	+10%		38.5%
2002	+8%	+10%		38.5%
2003	0%	0%		38.5%
2004	-2%	0%		35%
2005	-2%	0%		32%
2006	+15%	+5%	+25%	35%
2007	+6%	0%	+15%	35%
2008	+1%	0%	+5%	35%
2009	+5%	0%	+6%	37%
2010	+5%	0%	+7%	40%
2011	0%	0%	0%	40%

*For $800,000/$2,400,000 coverage

Class Definitions, Distributions and Rates

		FY09 # Providers	FY11 Rate*
Class 1	Physicians, No Surgery. Includes dermatology, pathology, psychiatry	584	$1,045
Class 2	Physicians, No Surgery	2,559	1,882
Class 3	Physicians, Minor Surgery	1,292	2,462
Class 4	Family Practitioners, including minor surgery and OB	181	2,754
Class 5	Surgery Specialty – Includes urology, colon/rectal, GP with major	256	3,170
Class 6	Surgery Specialty – Includes ER (no major), ENT	444	3,886
Class 7	Anesthesiology	319	3,245
Class 8	Surgery Specialty – Includes general, plastic, ER with major	318	7,459
Class 9	Surgery Specialty – Includes cardiovascular, orthopedic, traumatic	297	7,484
Class 10	Surgery Specialty – Includes OB/GYN	234	10,970
Class 11	Surgery Specialty – Neurosurgery	48	16,552
Class 12	Chiropractors	908	562
Class 13	Registered Nurse Anesthetists	602	1,081
Class 14	Podiatrists	98	2,546
Class 15	Availability Plan insureds	532	40%
Class 16	Professional corporations, partnerships	1,063	40%
Class 17	Medical care facilities	193	40%
Class 18	Mental health centers	24	40%
Class 19	Psychiatric hospitals	0	40%
Class 20	Residency training program	666	40%
Class 21	Other	0	40%
		10,620	

*$800,000/$2,400,000 Fund coverage, 5+ years of Fund compliance

PART IV

HCSF Technology Improvements

You may recall that in 2008 we hired a consulting firm to conduct a performance audit of HCSF operations. We contracted with a firm that specializes in consulting with insurance companies. The report by Virchow Krause and Company summarized our operations as follows:

> Overall, Virchow Krause identified that HCSF's systems and processes are heavily manual and paper based, provide limited real time and historical information tracking, have led to process inefficiencies, do not provide the functionality needed by users, and are not flexible or expandable enough to grow and adapt to the changing and evolving needs of HCSF. In addition, the systems are not fully integrated, do not provide electronic workflow and approval capabilities, and lack modern security features.

Following the Virchow Krause report our Board of Governors decided to invest in technology improvements in order to improve our operational efficiency. The first step was to budget our so-called KSIP funding for hardware and software upgrades as well as system design consulting. Then in 2009 our technology improvement plans had to be suspended because our funding for technology and professional development had been frozen by the Budget Director. Eventually that funding was taken from the Health Care Stabilization Fund and $251,834 was transferred to the State General Fund (another indirect tax on Kansas Health Care Providers).

A sympathetic House Budget Committee recommended an appropriation proviso that allowed us to spend $251,834 from our operating expenditures account in FY2010 for technology improvements and related professional development costs. This recommendation was eventually approved by the Legislature and in July 2009 we resumed our technology improvement project. One of the first things we did was seek the advice of consultants with specific experience developing management information systems for professional liability insurers. Based on their estimates, we included $800,000 in our FY2011 budget request for technology improvements and professional development. That request was rejected by the Budget Director and the Legislature.

In the meantime we entered into discussions with a company located in Johnson County that specializes in electronic documents management. We discovered that a number of other state agencies had already installed the software and were generally pleased with the system. The company was in the process of renewing its statewide contract, so we waited until that was accomplished to contract for the system. At about the same time, we hired a full-time Information Technology Officer.

We also entered into a contract with the Information Network of Kansas to host a new website. Our entire staff has devoted itself to developing a new, streamlined website with contemporary features. The new site is at www.hcsf.org. In about two months from now, our new website will provide a link to an electronic compliance form.

The compliance e-form will interact with our database such that if the insurer enters the health care provider's license number, several of the data fields will automatically populate from the existing HCSF data record. Of course certain fields that must be updated will remain blank and the insurance company representative will enter the information. Then when the e-form is submitted to us, it will be temporarily suspended for auditing. If it is complete and accurate and the surcharge payment has been received, we will simply accept the information and update our data record without a printed document or the time consuming task of data entry. This will be particularly helpful in those instances when the health care provider's compliance is time sensitive.

Our new website will also provide a link to the KanPay website which will allow the insurer or agent to submit the health care provider's surcharge payment using a credit card or electronic check. Of course there is a modest portal fee for this convenience. Users will also be able to pay the premium surcharges in a traditional manner.

In order to be prepared for the electronic compliance form, it has been necessary for us to make several improvements to our database. We hired a professional database developer to make the much needed changes and for the first time ever, to document the structure and design of our database.

The new website has been launched and we are currently in the final stages of testing our compliance e-form. We are planning to have the e-form available to begin calendar year 2011. If these new, electronic methods function as well as we expect them to, it may become unnecessary to purchase a complete, new management information system. While we may be able to avoid the expense of a new MIS, it will be necessary to afford continuous maintenance of our hardware, operating systems, and software. Funding for systems maintenance was approved in our FY2011 budget and has been requested again in our FY2012 budget.

Conclusion

Currently, HCSF assets exceed HCSF liabilities, but only marginally. While it appears that the Health Care Stabilization Fund is actuarially sound at this time, our financial integrity could change dramatically, depending on the Supreme Court decision in the case of Miller v. Johnson. If the Court's decision is to uphold the constitutionality of statutory limits on non-economic damages in personal injury actions, our financial condition will remain stable. If not, our currently assigned reserves will immediately become inadequate and our estimated liabilities will increase substantially. This means our assets will be insufficient and it will become necessary to increase premium surcharge rates. Our Board of Governors is anxiously waiting for the Court's decision.

APPENDIX

History and Significant Events

During the first half of the seventies decade, most Kansas physicians were confronted with upward spiraling professional liability insurance premiums. Some physicians could not purchase professional liability insurance at all. Those who could purchase insurance were oftentimes required to purchase policies with inadequate coverage. By 1975, several insurers had discontinued offering medical liability coverage in Kansas, and the remaining companies had reached their capacity. Some doctors continued to practice without professional liability insurance, but others limited their services in order to reduce their exposure to liability. It became increasingly difficult for patients to find physicians willing to perform surgery or deliver infants.

The 1976 Legislature responded to the crisis by passing the original version of the Health Care Provider Insurance Availability Act, which, among other things, created the Health Care Stabilization Fund. Responsibility for premium surcharge collections and administering the Stabilization Fund was delegated to the Insurance Commissioner. To accommodate those doctors who could not buy commercial insurance coverage, a joint underwriting association was created.

An important feature of the early version of the Availability Act was a requirement that insurers sell “claims made” rather than occurrence coverage. This was accompanied by a somewhat unique provision for prior acts coverage under the HCSF. In other words, the health care provider was insured for any claims made during the term of the insurance policy, regardless of when the incident occurred. Equally important, if the doctor retired or left Kansas to practice elsewhere, he or she had prior acts (tail) coverage via the HCSF for any claims that might arise after his or her claims made insurance policy was discontinued.

Unlike commercial insurance policies, the HCSF provided unlimited coverage. In other words, a doctor or hospital could be sued for any amount of money, and there was no limit on the amount a jury could award to a plaintiff, or the amount that could be agreed to in a settlement. Yet there was a statutory limit on the reserves that could be maintained in the Fund.

1980 was a significant year in the Fund’s history because 87 new cases were filed and the trend continued with 98 new cases in 1981. By the end of fiscal year 1982, the Fund had paid out over $5-million in losses and there was cause for alarm. It appeared obvious that accrued liabilities were rapidly exceeding Stabilization Fund assets.

The 1984 Legislature attempted to correct problems inherent in the original Act. The law was changed to limit the Fund's liability to $3-million per claim and $6-million annual aggregate liability. Another major amendment removed the statutory limit on the Fund's balance and prescribed that the premium surcharges should be based on estimated future liabilities. In other words, the Legislature decided the HCSF should be administered like an insurance plan, and should be actuarially sound.

During the second half of the eighties decade there was significant pressure on the Legislature to reform the rules of civil litigation. The medical profession and its allies engaged in an aggressive campaign for tort reform, whereas some members of the legal profession and certain consumer organizations were adamantly opposed. Eventually the Legislature passed a number of tort reform measures, and the cornerstone was a $250,000 limit on non-economic damages.

The controversy surrounding tort reform focused a great deal of attention on the HCSF because there were those who blamed the Fund for the cost of medical liability insurance. Some legislators insisted that the State should immediately divest from the HCSF. It was argued that in the absence of the Stabilization Fund, the commercial insurance industry would respond by offering adequate coverage to physicians and other health care professionals. But some legislators were concerned that Fund liabilities would exceed Fund assets and Kansas taxpayers would be left with an obligation to pay claims from general tax revenues. The compromise was passage of legislation that provided for a gradual phase-out of the Stabilization Fund.

In the meantime, the Legislature reduced the Fund coverage to $1-million per claim with annual aggregate limits of $3-million. Another important policy decision pertained to tail coverage. It was decided that a health care provider should contribute to the Fund at least five years before the provider could become inactive and receive the benefit of prior acts coverage. In other words, the tail coverage had to be purchased by payment of premium surcharges for at least five years.

The filing of new cases began to level off during the early nineties, and Fund assets gradually increased. By 1992 the Fund was considered actuarially sound, and premium surcharges were reduced accordingly. By this time interest in phasing out the HCSF diminished. Instead, the 1994 Legislature decided to remove the Fund from the Insurance Department and delegate responsibility for administration to the Board of Governors.

The HCSF Board of Governors is comprised of five physicians (three M.D.s and two D.O.s), three hospital representatives, one chiropractor, and one certified registered nurse anesthetist. The Board employs an executive director who advises the Board and manages routine operations of the agency.